

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

03010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Anne Arundelle</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pitche Hospital</u>		STREET ADDRESS <u>RFD #1 Herald Harbor</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Florence</u> (Middle) <u>May</u> (Last) <u>Ambrose</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 4 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>8/21/1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>working</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>67</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Schieb, Deceased</u>		14. MOTHER'S MAIDEN NAME <u>Emma Beauch, Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Adynamic ileus</u>			<u>3 days</u>
Antecedent cause(s) (b) <u>Hypertensive cardiovascular disease</u>			<u>over 25 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Generalized Arteriosclerosis</u>			<u>over 25 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>51</u> , to <u>March 4</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>March 4</u> , 19 <u>51</u> , and that death occurred at <u>1:55 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Robert Bogan</u>		ADDRESS <u>March 4, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>MAR. 7 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>WESTERN CEM.</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REG. <u>3/6/51</u>		24. FUNERAL DIRECTOR <u>William Cook, Jr.</u> ADDRESS <u>1217 ST. PAUL ST.</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH- COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Clear Spring		LENGTH OF STAY (in this place) 60 years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Clear Spring, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Paul's Road				STREET ADDRESS St. Paul's Road			
3. NAME OF DECEASED (Type or Print) Fannie		(Middle) Matilda		(Last) Ankeney		4. DATE OF DEATH Month March 7, 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH Aug. 10-1862	9. AGE last birthday 88 yrs.	If under 1 year Months	If under 1 year Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Rudolph Kreps				14. MOTHER'S MAIDEN NAME Elizabeth Kuhn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT AND ADDRESS Mrs. Raymond H. Miller		Clear Spring Md. R D	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

Arterio Sclerosis

(c)

INTERVAL BETWEEN
ONSET AND DEATH

7 years

10 years

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?							

22. I hereby certify that I attended the deceased from Aug. 1949, to Mar. 7, 1951, that I last saw the deceased alive on Mar. 7, 1951, and that death occurred at 5 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

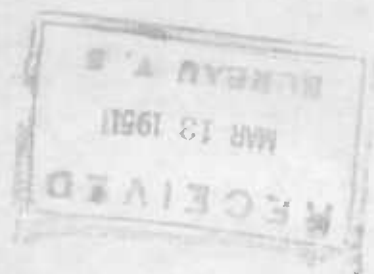
DATE SIGNED

David R. Brewer M.D.

Clear Spring Md.

3/9/51.

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Mar. 10-51		NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		LOCATION (City, town, or county) Route 40 E. Clspg.		(State)	
DATE REC'D BY LOCAL REG. Mar. 10/51		REGISTRAR'S SIGNATURE Joseph W. Munay		24. FUNERAL DIRECTOR Arvid T. Rowland		ADDRESS 720836			



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

03012

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>729 Spruce St.</u>		STREET ADDRESS (If rural, give location) <u>729 Spruce St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>CLARA</u>	(Middle) <u>ADELLA</u>	(Last) <u>AUMEN</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>26</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/14/1875</u>
9. AGE last birthday <u>76</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>
11. BIRTHPLACE (State or foreign country) <u>Truotville, Fred. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Anders</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Mae Shirley, Hagerstown Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
443x Immediate cause (a) <u>Hypertension Cardio-Vascular System</u>			<u>2 yrs</u>
93d Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/24/51</u> , 19....., to <u>3/26/51</u> , 19....., that I last saw the deceased alive on <u>3/24/51</u> , 19....., and that death occurred at <u>5 P</u>m., from the causes and on the date stated above.			
SIGNATURE <u>A. W. Ditto</u>		ADDRESS <u>Hagerstown Md</u> DATE SIGNED <u>3/26/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/28/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
DATE REC'D BY LOCAL REG <u>Mar 28 1951</u>	REGISTRAR'S SIGNATURE <u>Chas H. Bowers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>	

RECEIVED
MAR 30 1951
BUREAU Y. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03013

FILE NO. G 152 APR 9 1951

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>1014 Pope Avenue</u>	
3. NAME OF DECEASED (First) <u>Charles</u> (Middle) <u>Wilbur</u> (Last) <u>Baechtcl</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-17-1912</u>
9. AGE last birthday <u>39 yrs.</u>		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher Meat Cutter</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Roy Hoffman, Son</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wilbur T. Baechtcl</u>	
14. MOTHER'S MAIDEN NAME <u>Laura E. Semler</u>		15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>	
16. SOCIAL SECURITY NO. <u>214-09-0534</u>		17. INFORMANT AND ADDRESS <u>Mrs. C. Wilbur Baechtcl, Hagersn.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Generalized carcinomatosis</u>		<u>?</u>
Antecedent cause(s) (b) <u>Primary site unknown</u> <u>Metastatic leiomyosarcoma (4/9/51 aka)</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>Oct. 15, 1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>Generalized mesenteric + abdominal lymphadenopathy due to tumor</u>
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 15, 1951, to March 30, 1951, that I last saw the deceased alive on March 30, 1951, and that death occurred at 11 a. m., from the causes and on the date stated above.

SIGNATURE John A. Moran M.D. ADDRESS 215 W. Washington St. Hagerstown, Md. DATE SIGNED 3/31/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 4-2-1951 NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery LOCATION (City, town, or county) (State) Hagerstown, Md.

DATE REC'D BY LOCAL REG. Mar. 31, 1951 REGISTRAR'S SIGNATURE East Bowers 24. FUNERAL DIRECTOR C.M. Suter & Sons, Hagerstown, Md. ADDRESS

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APR 2 1961
BUREAU A-8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Earl Young

03014

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>912 Main Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>LONNIE</u>	<u>GENE</u>	<u>BAKER</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3/14/51</u>
9. AGE last birthday <u>--</u> yrs.		4. DATE OF DEATH (Month) (Day) (Year) <u>March 16 19 51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Baker</u>		14. MOTHER'S MAIDEN NAME <u>Grace Corder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Frank Baker Hagerstown Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
773.0 Immediate cause (a) <u>Cerebral Anoxia</u>		<u>2 Days</u>
158 Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
(c)		

II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
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21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3/14/51, 19....., to 3/16/51, 19....., that I last saw the deceased alive on 3/16/51, 19....., and that death occurred at 9 P.M. m., from the causes and on the date stated above.

SIGNATURE <u>R. L. Young M.D.</u>	(Degree or title)	ADDRESS <u>Willisport Md</u>	DATE SIGNED <u>3/17/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/16/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>
DATE REC'D BY LOCAL REG. <u>Mar 16/51</u>	REGISTRAR'S SIGNATURE <u>Phas H. Bowers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03015

CERTIFICATE OF DEATH

Reg. Dist. No. 303

112

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Big Pool</u> TOWN <u>Rural</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pectonville Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Big Pool, Md.</u> TOWN <u>Rural</u> STREET ADDRESS (If rural, give location) <u>Pectonville Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary Minerva Beard</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>8,</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 19, 1879</u>
9. AGE last birthday <u>71</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Wash. Co., Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Duties</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James M. Mills</u>		14. MOTHER'S MAIDEN NAME <u>Mary Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Alfred Shives- Big Pool, Md. RD</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Ventricular Fibrillation

Antecedent cause(s)

(b) Cardio Vascular(c) giving rise to the above cause stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

2 days6 monthsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 9/10/37 19....., to 3/7/57 19....., that I last saw the deceasedalive on 3/7/57 19....., and that death occurred at 4:11 m., from the causes and on the date stated above.SIGNATURE H. E. Tahler M.D.ADDRESS Hancock MarylandDATE SIGNED 3/7/57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar. 11-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Park Road Cemetery</u>	LOCATION (City, town, or county) (State) <u>W. Clear Spring, Md. Route 40</u>
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DATE REC'D BY LOCAL REG. <u>Made 11/51</u>	REGISTRAR'S SIGNATURE <u>Joseph W. Murray</u>	24. FUNERAL DIRECTOR <u>Adrian H. Rowland</u>	ADDRESS <u>720836</u>
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MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 20 1967
FBI - NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 144

03016

306

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Perryman</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		STREET ADDRESS (If rural, give location) <u>Box 23</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sophie</u> (Middle) <u>Virginia</u> (Last) <u>Bowser</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Dec. 5, 1874</u>
9. AGE last birthday <u>76</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Glevia Slawbury</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>unk.</u>	
17. INFORMANT AND ADDRESS <u>Hospital Record</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Hypertensive Cardio-vascular diseasemany yrs.

Antecedent cause(s)

(b) Generalized arterio-sclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.generalized arterio-sclerosismany yrs.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1, 1950, to Mar. 25, 1951, that I last saw the deceasedalive on March 25, 1951, and that death occurred at 1:15-2 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel Lai, M.D.Ritchie Hosp., Cascade, Md3/25/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mar. 25, 1951Blanchette S. EyerJohn R. CochranJohn R. Cochran

720836

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 28 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>1131 Hamilton Blvd.</u>	
3. NAME OF DECEASED (First) <u>Nannie</u> (Middle) <u>Gertrude</u> (Last) <u>Boxwell</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>8-12-1872</u>
9. AGE last birthday <u>78</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Frederick Co. Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>S. D. McDonald</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Esther Beachley</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Bronchial Asthma

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Arthritis, Rheumatism, multiple

INTERVAL BETWEEN ONSET AND DEATH

4-5 years -
asthma
36 hrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Arthritis, Rheumatism, multiple

5 years

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct, 1949, to March 25, 1951, that I last saw the deceasedalive on March 24, 1951, and that death occurred at 4 10 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>3-26-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Hillside Cemetery</u>	LOCATION (City, town, or county) <u>Plainfield, N. J.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Mar. 25, 1951</u>	REGISTRAR'S SIGNATURE <u>Frank H. Powers</u>	24. FUNERAL DIRECTOR ADDRESS <u>C. M. Suter & Sons, Hagerstown, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 27 1951
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

03018

1. PLACE OF DEATH- COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HAGERSTOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN RURAL- HAGERSTOWN, Rte #2	
HOSPITAL OR INSTITUTE OR STREET ADDRESS WASHINGTON CO. HOSPITAL		STREET ADDRESS (If rural, give location) HAGERSTOWN, Rte. #2	
3. NAME OF DECEASED (First) (Middle) (Last) DANIEL ESPY CARBAUGH		4. DATE OF DEATH (Month) (Day) (Year) 3 30 51	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH June 14, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TENANT FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	9. AGE last birthday 64 yrs.
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID RANKIN CARBAUGH		14. MOTHER'S MAIDEN NAME MARIA KING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) no		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS MR. OBERN CARBAUGH, WILLIAMSPORT, MD.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Shock following fracture skull				3/24/51	
Antecedent cause(s) (b) Chronic Alcoholism				20 yrs	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Chronic Alcoholism					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE Accident		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY #40		CITY OR TOWN (COUNTY) (STATE) 3 miles west of Hagerstown Washington MD	
TIME (Month) (Day) (Year) (Hour) OF INJURY 3-24-51 a.m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? Struck by auto	

22. I hereby certify that I attended the deceased from **3/24/51**, 19....., to **3/24/51**, 19....., that I last saw the deceased **alive on 3/24/51**, 19....., and that death occurred at **3:30 p.m.**, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

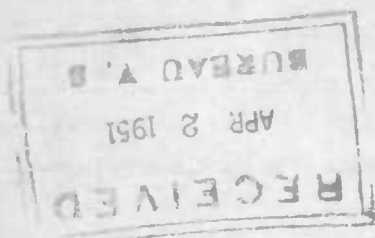
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 4/2/51	NAME OF CEMETERY OR CREMATORY BROADFORDING CEMETERY	LOCATION (City, town, or county) (State) WASHINGTON CO., MD.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Mar. 31, 1951		24. FUNERAL DIRECTOR W. S. Hornum, Hagerstown, Md.		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100105



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie State Hospital</u>		STREET ADDRESS (If rural, give location) <u>1312 W. Saratoga St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Drucilla</u> (First) <u>Chichester</u> (Last)		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negress</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>4/4/96</u>
9. AGE last birthday <u>54</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>John Berry</u>		14. MOTHER'S MAIDEN NAME <u>unknown Vivie Guss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) acute myocardial infarction
Antecedent cause(s) (b) Hypertensive Cardiovascular Disease
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Pagets Disease

INTERVAL BETWEEN ONSET AND DEATH

one day

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 4, 1951, to March 4, 1951, that I last saw the deceased

alive on March 4, 1951, and that death occurred at 10:12 P m. from the causes and on the date stated above.

SIGNATURE

Robert Hogan, M.D. Ritchie State Hosp.

(Degree or title)

ADDRESS

DATE SIGNED

3/4/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/7/51

AW Hedrick

James A. Stangis

638 N. Palmer St. Balt., Md.

JT

Balt., Md.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street address, hospital, or institution:
Washington Co. Hospital
 Length of mother's stay in County
 (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
 County Washington
 City or town 329 Valley Road Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 329 Valley Road
 (If RURAL give LOCATION)

3. Name of child David Dearhart Clugston

5. Sex Male 6. Twin or triplet

4. Date of birth Mar. 29th 1957 Hour 10:30 P.M.

7. No. of weeks pregnancy 32

FATHER OF CHILD

8. Full name Charles G. Clugston
 9. Color W. 10. Age at time of this birth 57 yrs.
 11. Usual occupation Assembly & Tester

MOTHER OF CHILD

12. Full maiden name Mrs. L. Shellenbarger
 13. Color W. 14. Age at time of this birth 32 yrs.
 15. Usual occupation House wife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 2
 (b) How many other children were born alive but are now dead? None (c) How many other children were born dead?

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of Placenta praevia

19. Labor: (a) Complications of _____ (b) Induced? No

20. (a) Was there an operation for delivery? Yes
 (b) State all operations, if any mid forceps

(c) Did child die before operation? No
 During operation? No

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity
 (b) Maternal causes Placenta praevia

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature Arthur Probst, Jr. M.D.
 (Specify if M. D., midwife or other)

Address Hagerstown, Maryland

23. (a) Burial (b) Date thereof 3/31/57
 (Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Rest Haven Cemetery

24. (a) Funeral director Rest Haven Funeral Chapel
 (b) Address Hagerstown, Md.

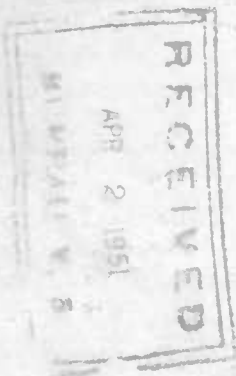
25. (a) Mar. 31, 1957 (b) 6 East Howard
 (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
 The above certificate has been examined by me.

Health Officer, per _____

* See Instruction C on stub.

CHILD LIVED --- 5 HOURS



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>220 North Potomac Street</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>220 North Potomac Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Harvey</u> (Middle) <u>Albert</u> (Last) <u>Cost</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-6-1866</u>
9. AGE last birthday <u>84</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Ret. Rwy. Postal Clk.</u>	
11. BIRTHPLACE (State or foreign country) <u>Keedysville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred N. Cost</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bovey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Richard A. Cost, Hagerstown</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute left ventricular failure</u>		<u>45 minutes</u>
Antecedent cause(s) (b) <u>Hypertension - Atherosclerotic Cardiovascular Disease</u>		<u>10 yrs.</u>
(c) <u>Benign hypertrophy of prostate</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7:21, 1941, to 3/26, 1951, that I last saw the deceased alive on 3/26, 1951, and that death occurred at 8:45 a. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-28-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
DATE REC'D BY LOCAL REG. <u>Mar. 29, 1951</u>	REGISTRAR'S SIGNATURE <u>Robert H. Humber</u>	24. FUNERAL DIRECTOR <u>C.M. Suter & Sons</u>	ADDRESS <u>Hagerstown, Md.</u>

390906

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 30 1951
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

03021

Reg. Dist. No. 3.05

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Roxbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rt. #3, Roxbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>No Street Address, Rt. #3</u>		STREET ADDRESS (If rural, give location) <u>No Address</u>	
3. NAME OF DECEASED (First) <u>James</u> (Middle) <u>H.</u> (Last) <u>Daymude</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>19</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8-24-1866</u>
9. AGE last birthday <u>84</u> yrs. If under 1 year Months <u>0</u> Days <u>28</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Loudoun Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Daymude</u>		14. MOTHER'S MAIDEN NAME <u>Emilt Mills</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. M. Burger, Hagerstown, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Vascular Disease</u>			<u>10 yrs</u>
Antecedent cause(s) (b) <u>Arteriosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Dr. W. S. Suter Jr.</u> (Degree or title)		ADDRESS <u>Hagerstown, Md.</u> DATE SIGNED <u>3/21/51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-21-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Mar. 21, 1951</u> <u>John H. B. East</u>		24. FUNERAL DIRECTOR <u>C.M. Suter & Sons, Hagerstown, Md.</u> ADDRESS	

510246



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr Zimmerman

03022 301

Reg. Dist. No. 502

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Martinsburg West Virginia</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Sanitarium</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Joseph Albert</u> (Middle) <u>Dermody</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>March 22/51</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Dec 25/80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B & O Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retiered</u>	9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Jacob Dermody</u>		14. MOTHER'S MAIDEN NAME <u>Odessa Gerberick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Miss Madaline Dermody</u>	
16. SOCIAL SECURITY NO. <u>unable to locate</u>		18. MEDICAL CERTIFICATION <u>Hagerstown Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

204.1 Immediate cause

(a) Leukemia, spleno myelogenous

Antecedent cause(s)

74a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) none

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 16, 1951, to May 22, 1951, that I last saw the deceasedalive on May 22, 1951, and that death occurred at 7:50 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/24/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem</u>	LOCATION (City, town, or county) <u>Hagerstown, Md</u>	(State)
DATE REC'D BY LOCAL <u>May 24/51</u>	REGISTRAR'S SIGNATURE <u>G Lee McHenry</u>	24. FUNERAL DIRECTOR <u>Andrew K Coffman</u>	ADDRESS <u>Hagerstown, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

VVO 506



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03023

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Wash. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Keedysville	
TOWN Hagerstown LENGTH OF STAY (in this place) 2 days		TOWN Keedysville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. County Hospital		STREET ADDRESS Main (If rural give location)	
3. NAME OF DECEASED (First) Clyde (Middle) Raymond (Last) Domer		4. DATE OF DEATH (Month) March (Day) 13 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 27, 1904
9. AGE last birthday 46 yrs.		10. If under 1 year: Months 1 Days 13 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cherry Orchard	
11. BIRTHPLACE (State or foreign country) Shepherdstown, W. Va		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank Domer		14. MOTHER'S MAIDEN NAME Mary Mahoney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 219-01-7378	
17. INFORMANT Mrs. Ruth Domer			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Generalized arterio-sclerosis

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

1 yr.

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF	While at			
INJURY	Work <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from *Dec. 15*, 19*50*, to *March 13*, 19*51*, that I last saw the deceased alive on *March 13*, 19*51*, and that death occurred at *6:30 P.* from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Mar 17, 1951	Fair-View	Keedysville, Md	
DATE REC'D BY LOCAL	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>Mar. 16, 1951</i>	<i>Charles H. Bowser</i>	R. I. Earnshaw--	Keedysville, Md	

820105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 19 1951
BUREAU A. H.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. Dotto

03024

Reg. Dist. No. 302

1. PLACE OF DEATH - COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Hagerstown, R.2		LENGTH OF STAY 5 years		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown,		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westernen Pike				STREET ADDRESS Westernen Pike		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) Harry		(First) Gross		(Last) Doub		4. DATE OF DEATH March 18 1951	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Mar. 28, 1882	
9. AGE last birthday 68		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Hagerstown	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David Rinehart Doub		14. MOTHER'S MAIDEN NAME Ann Catherine Funk		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY No. None		17. INFORMANT AND ADDRESS Mrs. Kenneth Long		18. MEDICAL CERTIFICATION Hagerstown, Md			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

2 days

21. ACCIDENT (Specify)
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒

22. I hereby certify that I attended the deceased from 3/14/51, 19....., to 3/19/51, 19....., that I last saw the deceased

alive on 3/14/51, 19....., and that death occurred at m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)
BurialDATE THEREOF
3/20/51NAME OF CEMETERY OR CREMATORY
Rose Hill CemeteryLOCATION (City, town, or county)
Hagerstown Md

(State)

DATE REC'D BY LOCAL REG.
3/20/51REGISTRAR'S SIGNATURE
W. W. Smith Jr.24. FUNERAL DIRECTOR
Andrew A. CoffmanADDRESS
Hagerstown Md

100105

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 22 1951
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03025

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>25 E. Potomac Street</u>	
3. NAME OF DECEASED (First) <u>Helen</u> (Middle) <u>V.</u> (Last) <u>Downs</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 24 1897</u>
9. AGE last birthday <u>54</u> yrs. Months <u>1</u> Days <u>5</u>		10. BIRTHPLACE (State or foreign country) <u>Martinsburg W. Va.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Chris Stocker</u>		14. MOTHER'S MAIDEN NAME <u>Lena Gerling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Norris Downs 25 E Potomac St. Williamsport Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral, Decubitus</u>			<u>4 hours</u>
Antecedent cause(s) (b) <u>Myocarditis, Pneumonia</u>			<u>3 years</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Nephritis, Sub acute</u>			<u>1 year</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1950</u> , 19....., to <u>Mar. 2</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Mar. 2</u> , 19 <u>51</u> , and that death occurred at <u>8:30 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>Williamsport Md.</u>	
DATE SIGNED <u>3/4/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>March 5 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		LOCATION (City, town, or county) <u>Williamsport Maryland</u>	
DATE REC'D BY LOCAL <u>Mar. 5/1951</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>Mr. Albert L. Leaf</u>		ADDRESS <u>Williamsport Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03026

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>322 W. Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN STREET ADDRESS <u>322 W. Washington</u>	
3. NAME OF DECEASED (Type or Print) <u>Gladys Marie Eversole</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Sept. 17, 1908</u>
9. AGE last birthday <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>	
11. BIRTHPLACE (State or foreign country) <u>Bentonville Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Phillip Henry</u>		14. MOTHER'S MAIDEN NAME <u>Florence Henry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-3737</u>	
17. INFORMANT AND ADDRESS <u>Russel Eversole Hag. Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma Lung

INTERVAL BETWEEN ONSET AND DEATH

14 mo.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

26 Nov 1949

19b. MAJOR FINDINGS OF OPERATION

Carcinoma of Rt. Lung

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 16 Nov, 1949, to 2 March, 1951, that I last saw the deceasedalive on 28 Feb, 1951, and that death occurred at 6:10 a m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

Burial

DATE THEREOF

Mar. 5, 1951

NAME OF CEMETERY OR CREMATORY

Baptist Cemetery

LOCATION (City, town, or county)

Bentonville Va.

(State)

DATE REC'D BY LOCAL

Mar. 5, 1951

REGISTRAR'S SIGNATURE

[Signature]

24. FUNERAL DIRECTOR

Scott F. Minnich & Son

ADDRESS

Hag. Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

643846



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

03027

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Near Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Nears Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Leitersburg, Pike</u>		STREET ADDRESS <u>Leitersburg Pike</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u>	(Middle) <u>Ellen</u>	(Last) <u>Finfrock</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 2, 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>81</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Shepherdstown, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Richard Hebb</u>		14. MOTHER'S MAIDEN NAME <u>Florence Hebb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Miss Beatrice Finfrock</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Arterio-sclerotic Heart Disease

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 12, 1951, to Mar 27, 1951, that I last saw the deceased alive on Mar 23, 1951, and that death occurred at 10 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

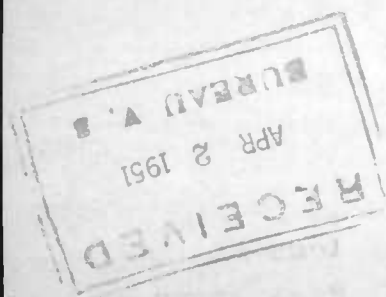
ADDRESS

Mar 29, 1951Edith H. HowerAndrew K CoffmanHagerstown Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03028 306
Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cascade		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cascade	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) NELLIE (Middle) (Last) FOX		4. DATE OF DEATH (Month) Mar. (Day) 12 (Year) 19 51	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 12/20/1881
9. AGE last birthday 69 yrs.		10. AGE last birthday (If under 1 year) Months Days (If under 24 hrs.) Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wolfsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rookland Blickenstaff		14. MOTHER'S MAIDEN NAME Ida Shuff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Grayson Fox Artana R#1, Pa.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause		(a) Company, Ocular w		Immediate	
(b) Antecedent cause(s)		(b) Arteriosclerotic Cardiovascular Disease		10 years	
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **June**....., 19**47**, to **March 12**, 19**51**., that I last saw the deceased alive on **11 March**., 19**51**., and that death occurred at **6:20 A.** m., from the causes and on the date stated above.

SIGNATURE **Robert B. Ferguson, M.D.** ADDRESS **Blue Ridge Summit Pa - 12 March 51** DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE **3/15/51** NAME OF CEMETERY OR CREMATORY **Lutheran Cemetery** LOCATION (City, town, or county) (State) **Foxville, Maryland**

DATE REC'D BY LOCAL REG. **Mar 14-51** REGISTRAR'S SIGNATURE **Geo W Ferguson** 24. FUNERAL DIRECTOR **A. Martin Poe** ADDRESS **Waynesboro, Pa.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

APR 15 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

03029

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital		STREET ADDRESS (If rural, give location) Route 6 Woodpoint	
3. NAME OF DECEASED (Type or Print)	(First) William	(Middle) L.	(Last) French
4. DATE OF DEATH	(Month) March	(Day) 11,	(Year) 51
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 24, 1890
9. AGE last birthday 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed - Various - Salvage	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT Country? U.S.	
13. FATHER'S NAME William H. French		14. MOTHER'S MAIDEN NAME Christiana M. Kline	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY No. 219-20-3432	
17. INFORMANT AND ADDRESS James L. French Hagerstown Rt. 6, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

1/2 hr.
3 wks.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

Feb. 5, 1951

Sigmoidal Abscess

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF injury bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb. 25, 1951, to March 11, 1951, that I last saw the deceased

alive on March 11, 1951, and that death occurred at 7 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Mar. 15, 1951	NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	LOCATION (City, town, or county) Hagerstown, Maryland	(State)
DATE REC'D BY LOCAL REG. Mar. 13, 1951	REGISTRAR'S SIGNATURE B. H. Bowers	24. FUNERAL DIRECTOR	ADDRESS Adrian H. Rowland Clear Spring, Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

03030

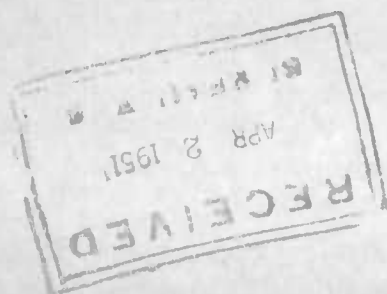
1. PLACE OF DEATH: COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>600 W. North Street</u>		STREET ADDRESS (If rural, give location) <u>600 W. North Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHARLES EDWARD GALLOWAY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3 / 27 / 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2/28/1881</u>
9. AGE last birthday <u>70</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Galloway</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Rev. L. L. Williams, 451 Broad Street, Harrisonburg, Va.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
a. Immediate cause <u>421X Chronic Endocarditis & Nephritis (?)</u>			
b. Antecedent cause(s) <u>92d Arterio-sclerosis</u>			
c. Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>421X</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>✓</u> SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) <u>✓</u> OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u>✓</u>			
22. I hereby certify that I attended the deceased from <u>3/22</u> , 19 <u>51</u> , to <u>3/27</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>51</u> , and that death occurred at <u>7-P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Victor D. Miller</u>		ADDRESS <u>401 W. Washington St.</u>	
DATE SIGNED <u>3/27/1951</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/30/1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
DATE REC'D BY LOCAL <u>Mar. 30, 1951</u>		REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	
24. FUNERAL DIRECTOR <u>William H. Downey</u>		ADDRESS <u>291 Fredrick St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

784836



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Pennsylvania</u> COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u> LENGTH OF STAY (in this place) <u>4 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt Alto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>65 East Ave</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Margaret</u> (Middle) <u>ANN</u> (Last) <u>GILBERT</u>	4. DATE OF DEATH	(Month) <u>3</u> (Day) <u>8</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>unmarried</u>	8. DATE OF BIRTH <u>7/31/1877</u>
9. AGE last birthday <u>73</u> yrs.	If under 1 year Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>on home</u>
11. BIRTHPLACE (State or foreign country) <u>Marysville, Perry County, Pa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S. H</u>	13. FATHER'S NAME <u>Benjamin Gordon</u>	14. MOTHER'S MAIDEN NAME <u>Lennis Divinsky</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	(If yes, give war or dates of service)	16. SOCIAL SECURITY No. <u>none</u>	17. INFORMANT <u>Mrs Fred Hussong, Hagerstown, Md.</u>

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Coronary Insufficiency</u>	INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
Antecedent cause(s) (b) <u>Hypertensive Heart Disease</u>	<u>10 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

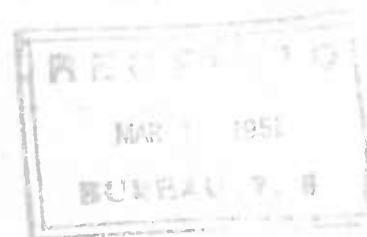
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1, 1940, to 3/7/51, 1951, that I last saw the deceased alive on 3/7/51, 1951, and that death occurred at 2:45 m., from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>	(Degree or title)	ADDRESS <u>Hagerstown, Md</u>	DATE SIGNED <u>3/9/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>3/10/51</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Shippensburg Pa</u>
DATE REC'D BY LOCAL REG <u>Mar 9, 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Walter J. Howe, Hagerstown, Pa</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Ditto

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

03032001

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown Rural</u> LENGTH OF STAY (in this place) <u>10 years</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown Rural</u> STREET ADDRESS (If rural, give location) <u>Downsville Pike</u>	
3. NAME OF DECEASED (First) <u>LEWIS</u> (Middle) <u>ELLERMAN</u> (Last) <u>GRAB</u>	4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>23</u> (Year) <u>1951</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 23, 1890</u>
9. AGE last birthday <u>61</u> yrs.		10. If under 1 year Months <u> </u> Days <u> </u>	11. If under 24 hrs. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	11. BIRTHPLACE (State or foreign country) <u>Columbia, Penna.</u>
13. FATHER'S NAME <u>Harry Grab</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Brunner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT AND ADDRESS <u>Mrs Leah Grab Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary ThrombosisAntecedent cause(s) (b) 420/1
94a
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3/23/51, 19....., to 3/23/51, 19....., that I last saw the deceased alive on 3/21/51, 19....., and that death occurred at 7:10 m., from the causes and on the date stated above.

SIGNATURE S. R. Dittus (Degree or title) ADDRESS Hagerstown Md. DATE SIGNED 3/24/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/23/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, of county) (State) <u>Hagerstown Md.</u>
DATE REC'D BY LOCAL REG. <u>Mar. 26, 1951</u>	REGISTRAR'S SIGNATURE <u>E. Lee McElroy</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100105

RECEIVED
APR 3 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03033 306

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		STREET ADDRESS <u>R #2</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u> (Middle) <u>W.</u> (Last) <u>Grable</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 14 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 5, 1897</u>
9. AGE last birthday <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cleaner - Dry Cleaner - Ritchie</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Grable</u>		14. MOTHER'S MAIDEN NAME <u>Harriette Grable</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>no 1918</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Hospital Record</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443x Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive Cardio-Vascular Disease(c) Hypertension

INTERVAL BETWEEN ONSET AND DEATH

10 hrs.

many years

many years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 12, 1949, to March 14, 1951, that I last saw the deceasedalive on March 14, 1951, and that death occurred at 6:20 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel Rai, M.D.Ritchie Hospital, Cascade, Md. March 14, 1951

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/14/51John A. CochranS. Maria PoeWAYNESBORO, PA.

643936

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 19 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03034 302

1. PLACE OF DEATH- COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL		STREET ADDRESS (If rural, give location) 137 RANDOLPH AVE.	
3. NAME OF DECEASED (Type or Print) DANIEL (First) JACOB (Middle) GROVE (Last)		4. DATE OF DEATH MARCH 4 1951	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 4/20/1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY EQUIPMENT CO.	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME DANIEL M. GROVE		14. MOTHER'S MAIDEN NAME REGINA C. STECK	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-5881	17. INFORMANT AND ADDRESS MR. DANIEL W. GROVE HAGERSTOWN MD.

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Cerebral hemorrhage	2 days.	
Antecedent cause(s) (b) 331X 83a Vascular hypertension - arteriosclerosis	years	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) none	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **March 2, 1951**, to **March 4, 1951**, that I last saw the deceased alive on **March 4, 1951**, and that death occurred at **9:40 p.m.**, from the causes and on the date stated above.

SIGNATURE **W. J. Herment** (Degree or title) ADDRESS **119 E. Artichoke St. Hagerstown Md.** DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3/7/51	NAME OF CEMETERY OR CREMATORY St. Paul's Cem.	LOCATION (City, town, or county) (State) Washington County, Md.
DATE REC'D BY LOCAL REG. March 6, 1951	REGISTRAR'S SIGNATURE W. J. Herment	24. FUNERAL DIRECTOR W. J. Herment	ADDRESS Hagerstown Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 8 1961
R. G. W. A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03035

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAGERSTOWN- Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAGERSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HAGERSTOWN, Route 5</u>		STREET ADDRESS <u>901 SOUTH POTOMAC ST.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LOLA</u>	(Middle) <u>LAVINA</u>	(Last) <u>GROVE</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Oct. 30, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9. AGE last birthday <u>73</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>FREDERICK CO., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARTIN V. ARNOLD</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN ANN HUPT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>MRS. JOHN MILLER, RTE 5, HAGERSTOWN, MD.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Arterio-sclerotic Heart Disease</u>			<u>4 years.</u>
Antecedent cause(s) (b) <u>420.0</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>93d</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Feb 28, 1951, to Feb 29, 1951, that I last saw the deceased alive on Feb 28, 1951, and that death occurred at 2:15 P. m., from the causes and on the date stated above.

SIGNATURE [Signature] ADDRESS Hagerstown DATE SIGNED 3/30/51

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL DATE 3/31/51 NAME OF CEMETERY OR CREMATORY ST. PAUL'S CEMETERY LOCATION (City, town, or county) WASHINGTON CO., MD.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Mar. 30, 1951 [Signature] 24. FUNERAL DIRECTOR W. J. Normant ADDRESS Hagerstown, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 2 1951
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition
in 21 shown on:

FILM No. G 152 APR 18 1951

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03036

Reg. Dist. No. 307

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>234 E. Franklin St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS <u>234 E. Franklin St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Walter</u>	(Middle) <u>Garver</u>	(Last) <u>Gruber</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-10-1903</u>
9. AGE last birthday <u>47</u> yrs.		10. If under 1 year Months <u>11</u> Days <u>7</u>	11. If under 24 hrs. Hours <u>11</u> Min. <u>51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed - Upholsterer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Frederick D. Gruber</u>		14. MOTHER'S MAIDEN NAME <u>Cora Garver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>214-19-9487</u>	
17. INFORMANT <u>Mrs. Walter G. Gruber</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Immediate cause</u> <u>Acute barbiturate poisoning (Amytal)</u>			
(b) <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) <u>Blood contained 1.9 mg. % barbiturate</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-----</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Took over dose of sodium amytal</u>		(CITY OR TOWN) <u>Hagerstown</u> (COUNTY) <u>Wash</u> (STATE) <u>Md</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>S. Robert Wells M.D.</u>		ADDRESS <u>115 N. Potomac St.</u> DATE SIGNED <u>Mar. 3, 51</u>	
23. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		DATE THEREOF <u>3-7-1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenhill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Waynesboro, Pa.</u>	
DATE REC'D BY LOCAL REG. <u>Mar. 8, 1951</u>		REGISTRAR'S SIGNATURE <u>Brash Bowers</u>	
24. FUNERAL DIRECTOR <u>C.M. Suter & Sons, Hagerstown, Md.</u>		ADDRESS	

593817

RECEIVED
MAR 10 1951
BUREAU V. B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Ditto 03037

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> LENGTH OF STAY (in this place) <u>3 yrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>47 Devonshire Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>47 Devonshire Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>RUDOLPH</u> <u>HARDY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 4 1951</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 11 1886</u>
9. AGE last birthday <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crossing Flag Man</u>	
11. BIRTHPLACE (State or foreign country) <u>Pleasantville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Hardy</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Ridenour</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>705-10-1732</u>	
17. INFORMANT AND ADDRESS <u>Mrs Anna B. Hardy</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive Cardio Vascular Disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

4 years

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1-1-1947, to 3-4-1951, that I last saw the deceased alive on 2-27-1951, and that death occurred at m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/7/51</u>	NAME OF CEMETERY OR CREMATORY <u>Samples Manor Cemetery</u>	LOCATION (City, town, or county) <u>Samples Manor Md</u>	(State)
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Mar 7, 1951</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md</u>		

690506

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
MAR 9 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03038

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1121 Oak Hill Avenue</u>		STREET ADDRESS (If rural, give location) <u>1121 Oak Hill Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Frank</u> (First) <u>Merrill</u> (Middle) <u>Hays</u> (Last)		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>23</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8-12-1885</u>
9. AGE last birthday <u>65</u> yrs.		10. If under 1 year: Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Retail Stationer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rufus M. Hays</u>		14. MOTHER'S MAIDEN NAME <u>Laura Heard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE 214-09-1446</u>	
17. INFORMANT AND ADDRESS <u>Mrs. F. Merrill Hays, Hagerstown</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332x
83b

Immediate cause

(a)

Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 yrs

Antecedent cause(s)

(b)

Arteriosclerosis, Cerebral3 yrs

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Hypertensive Vascular Disease5 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1948, to Mar 23, 1951, that I last saw the deceasedalive on March 23, 1951, and that death occurred at 4:00 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Salmon M. Welby M.D.Hagerstown, Md.3-23-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mar 26 1951Phoebe HowardC.M. Suter & Sons, Hagerstown, Md.290698.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. Layman

03039

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hosp.</u>		STREET ADDRESS (If rural, give location) <u>39 N. Foundry St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>BERTHA</u>	(Middle) <u>ELLEN</u>	(Last) <u>HENSON</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 14, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>71</u> yrs.
13. FATHER'S NAME <u>John Ripple</u>		11. BIRTHPLACE (State or foreign country) <u>Falling Waters, W.Va.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. SOCIAL SECURITY NO. <u>None</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ridenour</u>	
17. INFORMANT AND ADDRESS <u>Mrs Viola Scott</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Contraction heart failure</u>			<u>8 hours</u>
Antecedent cause(s) (b) <u>Phrenetic heart disease with multiple valvular defects</u>			<u>Presumably years</u>
(c) <u>Bronchial Asthma</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 1948</u> , to <u>Feb 28 1951</u> , that I last saw the deceased alive on <u>Feb 28 1951</u> , and that death occurred at <u>7 A.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. Layman, M.D.</u>		ADDRESS <u>Hagerstown Md. March 3, 1951</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/3/51</u>	
NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>		LOCATION (City, town, or county) (State) <u>Williamsport Md.</u>	
DATE REC'D BY LOCAL REG. <u>Mar. 3, 1951</u>		24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	
REGISTRAR'S SIGNATURE <u>W. H. Flowers</u>		ADDRESS <u>Hagerstown Md.</u>	

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03040

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hosp.</u>		STREET ADDRESS (If rural, give location) <u>751 Spruce Street</u>	
3. NAME OF DECEASED (First) <u>Ella</u> (Middle) <u>M.</u> (Last) <u>Herr</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>22</u> , (Year) <u>51</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 14, 1893</u>
9. AGE last birthday <u>57</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nicholas Hartman</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Rudolph R. Herr Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Pulmonary Embolism

INTERVAL BETWEEN ONSET AND DEATH

3 hrs.

Antecedent cause(s)

(b)

Int. mural thrombosis - Rt. Ventricle?

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

Influenza4 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 21, 1951 to March 22, 1951, that I last saw the deceasedalive on March 22, 1951, and that death occurred at 6:07 p.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mar. 24, 1951Chas. H. BrownFred W. KraissHagerstown, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 27 1951
BUREAU Y. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03041

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u> LENGTH OF STAY (in this place) <u>1 month</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sharpsburg Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>Main St. Sharpsburg Md.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mildred</u> (Middle) <u>Edna</u> (Last) <u>Hoover</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 8 1893</u>
9. AGE last birthday <u>57</u> yrs.		10. If under 1 year: Months <u>3</u> Days <u>20</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Near Sharpsburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Malcolm Victor Smith</u>		14. MOTHER'S MAIDEN NAME <u>Sallie D Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Harry Hoover Sharpsburg Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of the Gall bladder

INTERVAL BETWEEN ONSET AND DEATH

1 Yr (3)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Diabetes mellitus

10 Yrs

19a. DATE OF OPERATION <u>1/10/51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Ca. G.B. with extension to liver & abdomen</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/11, 1950., to 3/1/51 19....., that I last saw the deceased

alive on 2/28, 1951, and that death occurred at 5:40A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

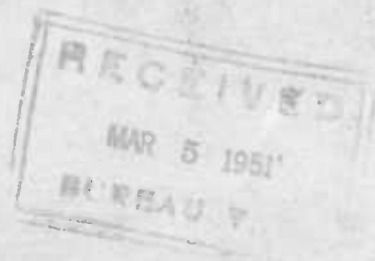
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 3-51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	LOCATION (City, town, or county) (State) <u>Sharpsburg Maryland</u>
DATE REC'D BY LOCAL REG. <u>Mar. 3, 1951</u>	REGISTRAR'S SIGNATURE <u>Frank H. Bowers</u>	24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

03042

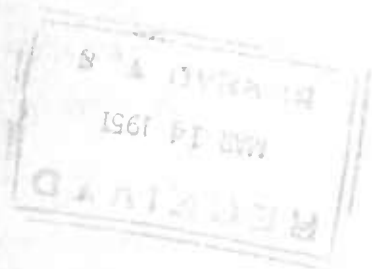
1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) Boonsboro		CITY (If outside corporate limits, write RURAL and give nearest town) Boonsboro R. F. D. #1	
TOWN Boonsboro LENGTH OF STAY (in this place) 2 weeks		TOWN Boonsboro R. F. D. #1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Guilford Con. Home		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) Charles (Middle) Franklin (Last) Hopper		4. DATE OF DEATH (Month) March (Day) 10 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH May 20, 1863
9. AGE last birthday 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11. BIRTHPLACE (State or foreign country) Allentown, Penns.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY No. None	
17. INFORMANT Mr. William Wells			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause Gangrene		1 Mo. 9 days	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last Arterio Sclerosis		" "	
(c) Myocarditis		" "	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. General Debility		" "	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 1, 1951 , to Mar. 10, 1951 , that I last saw the deceased alive on Mar. 10, 1951 , and that death occurred at 9:45 P.m. , from the causes and on the date stated above.			
SIGNATURE Arthur H. Wade		DATE SIGNED 3/12/51	
(Degree or title) M. D.		ADDRESS Boonsboro, Md.	
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Mar. 13, 1951	NAME OF CEMETERY OR CREMATORY Rose-Hill	LOCATION (City, town, or county) (State) Hagerstown - MD
DATE REC'D BY LOCAL REG March 12, 1951	REGISTRAR'S SIGNATURE John W. East	24. FUNERAL DIRECTOR R. I. Earnshaw-Keedysville, Md.	ADDRESS

510246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03043

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Marble</u> LENGTH OF STAY (in this place) <u>40 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Marble</u> <u>Mangansville md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Hagerstown RD #4</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARTIN</u> <u>L</u> <u>HORST</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar</u> <u>6</u> <u>1951</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 23. 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE last birthday <u>72</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob L Horst</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Memo Horst</u>		<u>Hagerstown RD 4</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) <u>Pulmonary edema</u>		
Antecedent cause(s) (b) <u>Myocardial infarction?</u>		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Myocarditis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Seen after death.</u>		<u>Indefinite</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased on 3-6-51, to river, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 400A m., from the causes and on the date stated above.

SIGNATURE Robert F. Keadle (Degree or title) MP ADDRESS 132 W Wash Hagerstown DATE SIGNED 3-6-51

23. BURIAL, CREMATION REMOVAL (Specify) B DATE Mar 8. 1951 NAME OF CEMETERY OR CREMATORY Reiff Cemetery LOCATION (City, town, or county) (State) near Carlisle md

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Mar 6 1951 Charles Cowell 24. FUNERAL DIRECTOR A.E. Minnich ADDRESS Greencastle

180105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03044

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Clear Spring Rural Rt. 2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>Indian Springs</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u> (Middle) <u>Catherine</u> (Last) <u>Hovermale</u>	4. DATE OF DEATH	(Month) <u>March</u> (Day) <u>24</u> , (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Mar. 24, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday yrs. <u>3</u> Months <u>41</u> Days <u>41</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William P. Hovermale</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Jacobs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>William P. Hovermale Clear Spring 2</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Prematurity</u>			<u>3 mo - 41</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last <u>(1st 6 mo)</u>			
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb 24, 1951</u> to <u>Feb 24, 1951</u> , that I last saw the deceased alive on <u>Feb 24, 1951</u> , and that death occurred at <u>9:37 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u> (Degree or title)		ADDRESS <u>Hagerstown Md.</u> DATE SIGNED <u>3/27/51</u>	
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Mar. 28, 1951</u>	<u>Clearspring, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Mar. 28, 1951</u>	<u>[Signature]</u>	<u>Adrian H. Rowland</u>	<u>Clear Spring</u>

213241 202 240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 30 1951
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03045

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Rt. 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital		STREET ADDRESS (If rural, give location) Indian Springs	
3. NAME OF DECEASED (Type or Print)	(First) William	(Middle) P.	(Last) Hovermale III
4. DATE OF DEATH	(Month) March	(Day) 25,	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Mar. 24, 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William P. Hovermale		14. MOTHER'S MAIDEN NAME Mary C. Jacobs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT AND ADDRESS William P. Hovermale Clear Spring 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity

Antecedent cause(s) (1st. 1090)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

11 hrs. 9 min.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒ 6

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March 24, 1951, to March 25, 1951, that I last saw the deceased alive on March 24, 1951, and that death occurred at 5:20 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Mar. 28, 1951	NAME OF CEMETERY OR CREMATORY Hagerstown Ind.	LOCATION (City, town, or county) Clearspring, Md.	(State)
DATE REC'D BY LOCAL REG. Mar. 28, 1951	REGISTRAR'S SIGNATURE Charles H. Bowers	24. FUNERAL DIRECTOR Adrian H. Rowland	ADDRESS Clear Spring, Md.	

213241203994

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

03046

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown R.F.D.#3</u> LENGTH OF STAY (in this place) <u>41 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rt. #3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hagerstown R.F.D.#3</u>		STREET ADDRESS (If rural, give location) <u>Hagerstown R.F.D.#3</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lottie</u> (Middle) <u>Marie</u> (Last) <u>Ingram</u>	4. DATE OF DEATH	(Month) <u>Mar.</u> (Day) <u>31</u> (Year) <u>19 51</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-29-1886</u>
9. AGE last birthday <u>65</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Fulton County, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis E. Mills</u>		14. MOTHER'S MAIDEN NAME <u>Christine Houch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>W. Roy Ingram, R.F.D.#3</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

10 min

Antecedent cause(s)

(b)

Hypertensive Heart Disease8 yrs

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Diabetes Mellitus4 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE HOMICIDE	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1935, 19 3/30, 19 51, that I last saw the deceasedalive on 3/29, 19 51, and that death occurred at 9:00 P m., from the causes and on the date stated above.SIGNATURE [Signature]

(Degree or title)

ADDRESS Hagerstown MdDATE SIGNED [Signature]

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4-4-1951</u>	<u>Rose Hill Cemetery</u>	<u>Hagerstown, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>Apr. 3, 1951</u>	<u>[Signature]</u>	<u>C. M. Suter & Sons, Hagerstown, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington G. Hospital</u>		STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print) <u>Carrie Elizabeth Keller</u>		4. DATE OF DEATH <u>March 29, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-12-1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	9. AGE last birthday <u>59</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Elmer Harshman</u>		14. MOTHER'S MAIDEN NAME <u>Laura Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Harry Keller Middletown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

570.2 Immediate cause
Antecedent cause(s)
99 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Mesenteric Thrombosis & Gangrene of Cecum
(b) Hypertensive Cardio-Vascular Disease

INTERVAL BETWEEN ONSET AND DEATH

2 days
5 yrs +

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>MAR. 28, 51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Gangrene of Cecum</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u></u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u></u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u></u>

22. I hereby certify that I attended the deceased from MAR 28, 1951 to MAR. 29, 1951, that I last saw the deceased

alive on MAR. 29, 1951, and that death occurred at 5:25 P.M., from the causes and on the date stated above.

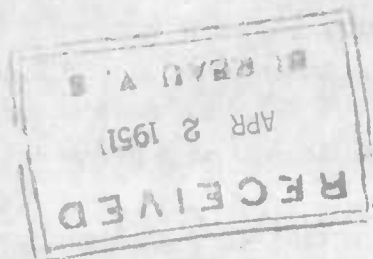
SIGNATURE Robert B. Hower M.D. (Degree or title) ADDRESS Hagerstown Md DATE SIGNED 3/30/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>4-1-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	LOCATION (City, town, or county) (State) <u>Myersville, Md.</u>
DATE REC'D BY LOCAL REG. <u>MAR 30, 1951</u>	REGISTRAR'S SIGNATURE <u>Robert B. Hower</u>	24. FUNERAL DIRECTOR <u>Bladhill G. Middletown, Md.</u>	ADDRESS <u></u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03048

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>120 Blooms Alley</u>		STREET ADDRESS (If rural, give location) <u>160 Blooms Alley</u>	
3. NAME OF DECEASED (Type or Print) <u>FRANCES</u> (First) <u>KENNEDY</u> (Last)		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9/15/1863</u>
9. AGE last birthday <u>87</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	
11. FATHER'S NAME <u>Moses Snively</u>		12. MOTHER'S MAIDEN NAME <u>Unknown</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		14. SOCIAL SECURITY NO. <u>None</u>	
15. INFORMANT AND ADDRESS <u>Mrs. Mary Keys 240 W. Jonathan St.</u>		16. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

4200

Antecedent cause(s)

(b)

93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 21, 1951, to March 22, 1951, that I last saw the deceasedalive on March 21, 1951, and that death occurred at 1:50 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. FUNERAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

RECEIVED
MAR 27 1951
BUREAU F. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03049

Reg. Dist. No. 306

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Washington</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Near Smithsburg</u> TOWN <u>All her life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Near Smithsburg</u> TOWN <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>No Hospital, or Street address.</u>		STREET ADDRESS <u>none</u> (If rural, give location) <u>Rural.</u>	
3. NAME OF DECEASED (Type or Print) <u>Lenora</u> (First)	<u>Blaine</u> (Middle)	<u>Kline</u> (Last)	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>29</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-m. 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping all her life</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	9. AGE last birthday <u>52</u> yrs. <u>53</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Near Smithsburg and</u>		12. CITIZEN OF WHAT COUNTRY? <u>Washington</u>	
13. FATHER'S NAME <u>Charles V. Heffner</u>		14. MOTHER'S MAIDEN NAME <u>Fannie B. Arkdott.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Marshall Kline</u>			

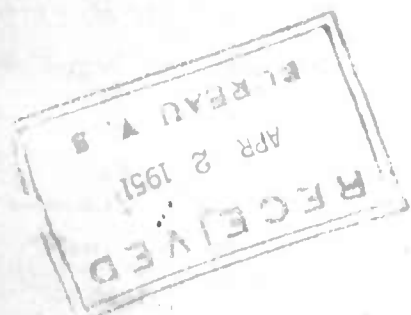
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral hemorrhage</u>			<u>6 hrs</u>
Antecedent cause(s) (b) <u>Hypertension, cerebral arterio sclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>83a</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>-</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>-</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>-</u>	(CITY OR TOWN) <u>-</u>	(COUNTY) <u>-</u> (STATE) <u>-</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>-</u>	

22. I hereby certify that I attended the deceased from Mar 29, 1951, to March 29, 1951, that I last saw the deceased alive on Mar 29, 1951, and that death occurred at 9:00 p.m., from the causes and on the date stated above.

SIGNATURE <u>Walter L. Wolfinger - M.D.</u>	ADDRESS <u>122 So Broad St., Waynesboro Pa.</u>	DATE SIGNED <u>3-30-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4/1/51</u>	NAME OF CEMETERY OR CREMATORY <u>Smithsburg</u>
LOCATION (City, town, or county) <u>Smithsburg</u>	(State) <u>Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Mar 30-51</u>	REGISTRAR'S SIGNATURE <u>Geo W Ferguson</u>	24. FUNERAL DIRECTOR <u>Geo B Hooper Smithsburg Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition
of 4 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03050

Reg. Dist. No. 302

FILM No. G 151 APR 2 1951

1. PLACE OF DEATH: COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Fredrick</u>	
CITY (If outside corporate limits, write give nearest town) <u>Adams town</u>		CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Blackfield</u>	
TOWN <u>Adams town</u>		TOWN <u>Blackfield</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garlock Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>March 18 1951</u>	
3. NAME OF DECEASED (Type or Print) <u>Lela Virginia Lantz</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 18 1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 24-1865</u>
9. AGE last birthday <u>86</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Ind.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	13. FATHER'S NAME <u>not known</u>	14. MOTHER'S MAIDEN NAME <u>not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY No. <u>no</u>	17. INFORMANT AND ADDRESS <u>Mrs. Rosa S. Lantz, Lantz Ind.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Hypertensive Cardiovascular Disease

Antecedent cause(s)

(b)

R.B. hemiplegia

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Aug. 4, 1949, to Mar. 18, 1951, that I last saw the deceased

alive on Mar. 10, 1951, and that death occurred at 2:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. Howard Weaver, M.D. Stegentown, Ind.

3-20-59

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar. 26 1951</u>	NAME OF CEMETERY OR CREMATORY <u>W. B. Cemetery</u>	LOCATION (City, town, or county) <u>Thurmont</u>	(State) <u>Ind.</u>
DATE REC'D BY LOCAL REG. <u>Mar 31 51</u>	REGISTRAR'S SIGNATURE <u>W. B. Weaver</u>	24. FUNERAL DIRECTOR <u>M. R. Weaver</u>	ADDRESS <u>San Thurmont</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03051

Reg. No. G 132 APR 5 1951

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Hagerstown</u> <u>Washington Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Washington</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>515 Reynolds ave</u>		STREET ADDRESS (If rural, give location) <u>515 Reynolds Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Arnon Lawrence</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3</u> <u>27</u> <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3-21-1853</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farms</u>	9. AGE last birthday <u>98</u> yrs. <u>0</u> Months <u>6</u> Days
11. BIRTHPLACE (State or foreign country) <u>Littleton Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Washington</u>	
13. FATHER'S NAME <u>Jermie Lawrence</u>		14. MOTHER'S MAIDEN NAME <u>Madaga Leve, Pfeiffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>Res. Pa.</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary Siegous, 515 Reynolds Ave.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4222 Immediate cause (a) Myocardial failure

Antecedent cause(s)

932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic myocarditis (4/4/51 akc)

(c) None

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-26, 1951, to 3-27, 1951, that I last saw the deceased

alive on 3-26, 1951, and that death occurred at 10:00 A. m., from the causes and on the date stated above.

SIGNATURE L. B. Bell

(Degree or title) M. D.

ADDRESS Hagerstown, Maryland.

DATE SIGNED Mar. 27, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Mar 29-51

NAME OF CEMETERY OR CREMATORY Rose Hill

LOCATION (City, town, or county) Hagerstown

(State) Md.

DATE REC'D BY LOCAL REG Mar. 28, 1951

REGISTRAR'S SIGNATURE Robert Bowers

24. FUNERAL DIRECTOR Albert L. Leaf

ADDRESS Halfway Md.

1004051



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19 E. Lee St</u>		STREET ADDRESS (If rural, give location) <u>19 E. Lee St</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u> (Middle) <u>Otterbein</u> (Last) <u>Long</u>	4. DATE OF DEATH	(Month) <u>March</u> (Day) <u>28</u> (Year) <u>1951</u>
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>April 15, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>65</u> yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
11. FATHER'S NAME <u>Joseph H. Long</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. MOTHER'S NAME <u>Margaret Caroline Shank</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>214-09-8472</u>	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. William O. Long</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Strangulation inguinal hernia</u>	<u>Hypertensive cardiovascular disease</u>	<u>7 days</u>
Antecedent cause(s)	(b) <u>fecal fistula</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>(Hypertensive surgery refused)</u>		
II. OTHER SIGNIFICANT CONDITIONS		19. DATE OF OPERATION	
Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
HOMICIDE	INJURY			
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY				

22. I hereby certify that I attended the deceased from Feb, 1951, to March 28, 1951, that I last saw the deceased alive on March 23, 1951, and that death occurred at 3:10 P m., from the causes and on the date stated above.

SIGNATURE W. J. Layman, M.D. ADDRESS Hagerstown, Md DATE SIGNED March 29

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/30/51</u>	<u>Rosedale Cemetery</u>	<u>Martinsburg</u>	<u>W. Va.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Mar. 29, 1951</u>	<u>W. J. Layman</u>	<u>Kogelschatz & Coffman</u>	<u>Martinsburg, West Virginia</u>	

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
APR 2 1951
U. S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03053

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>WASHINGTON</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>268 S. POTOMAC ST.</u>		STREET ADDRESS <u>268 S. POTOMAC ST.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ANNIE</u>	(Middle) <u>MARIA</u>	(Last) <u>LOUGHERY</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>FEB. 5, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during past 12 months, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9. AGE last birthday <u>77</u> yrs.
13. FATHER'S NAME <u>WILLIAM NICARRY</u>		14. MOTHER'S MAIDEN NAME <u>EMMA SMITH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>MISS PAULINE LOUGHERY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Influenza</u>			<u>36 hrs</u>
(b) Antecedent cause(s) <u>Diabetes mellitus</u>			
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>none</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, or office hldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 4, 1951, to March 5, 1951, that I last saw the deceased alive on March 4, 1951, and that death occurred at 3:25 A m., from the causes and on the date stated above.

SIGNATURE W. J. Norment (Degree or title) ADDRESS 119 E. Antietam St. Hagerstown, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3/6/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Mar. 6, 1951</u>	24. FUNERAL DIRECTOR <u>W. J. Norment</u>	ADDRESS <u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03054

CERTIFICATE OF DEATH

Reg. Dist. No. 302

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY Washington CITY (If outside corporate limits, write RURAL and OR give nearest town) Hagerstown TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. County Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Wash. CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown TOWN STREET ADDRESS (If rural, give location) 127 E. Baltimore St.	
3. NAME OF DECEASED (Type or Print)	(First) Anna	(Middle) E.	(Last) Lushbaugh
4. SEX Female	5. COLOR OR RACE White	6. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) Widowed	7. DATE OF BIRTH Nov. 21, 1881
8. AGE last birthday 69 yrs.	9. DATE OF DEATH Mar. 11	10. DATE OF DEATH (Month) Mar. (Day) 11 (Year) 1951	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Near Williamsport Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Theodore Pitsnogle		14. MOTHER'S MAIDEN NAME Anna E. Gossard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, or unknown) No		16. SOCIAL SECURITY NO. 217-12-2613	
17. INFORMANT AND ADDRESS Mrs. Drexel Lushbaugh		Hag. Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

95a
95b
14 yrs certain

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct. 1950**, to **March 11, 1951**, that I last saw the deceased alive on **March 11, 1951**, and that death occurred at **8:30 AM** from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mar. 14, 1951**Phoebe Flowers****Scott F. Minnich & Son****Hag. Md.**

MARGIN RESERVED FOR BINDING

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03055

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>409 Freemont St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Harrison Lee Lushbaugh Jr.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 24 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>March 23 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>0</u> yrs. If under 1 year Months. Days <u>22</u> <u>16</u>
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Harrison Lee Lushbaugh, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Thomazine Marcella Smedley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>mother</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Pneumonia (3 obs)</u>		<u>1 Day</u>
Antecedent cause(s) (b) <u>159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
II. OTHER SIGNIFICANT CONDITIONS (c) Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>3/23/51</u> 19....., to <u>3/24/51</u> 19....., that I last saw the deceased alive on <u>3/24/51</u> 19....., and that death occurred at <u>8 A.</u> m., from the causes and on the date stated above.		
SIGNATURE (Degree or title) <u>Young M.D.</u>		ADDRESS <u>Williamsport, Md.</u> DATE SIGNED <u>3/26/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>3/26/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u> LOCATION (City, town, or county) <u>Hagerstown Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>Mar. 26 1951</u>	REGISTRAR'S SIGNATURE <u>Black, J. Zowere</u>	24. FUNERAL DIRECTOR <u>Andrew H. Coffman</u> ADDRESS <u>Hagerstown Md.</u>

203331/61282

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03056304

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hancock</u> LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hancock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>High Street</u>		STREET ADDRESS (If rural, give location) <u>High Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Josephine</u> <u>Macdonald</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar.</u> <u>13</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3-8-65</u>
9. AGE last birthday <u>86</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Rowland</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT <u>Richard Keplinger (nephew)</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
Immediate cause (a) <u>Cerebral Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
Antecedent cause(s) (b) <u>Arteriosclerosis</u>		<u>Unknown</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>nothing of significance</u>		<u>more than 20 yrs.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 28, 1951, to March 13, 1951, that I last saw the deceased alive on 2/13/51, 1951, and that death occurred at 5:30 PM m., from the causes and on the date stated above.

SIGNATURE <u>J. H. Gable, M.D.</u> ADDRESS <u>Hancock, Md.</u>		DATE SIGNED <u>3/15/51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)			
<u>Burial</u> <u>3-17-51</u> <u>St. Thomas Episc. Cem.</u> <u>Hancock</u> <u>Md.</u>			
DATE RECEIVED BY LOCAL REG. <u>3/18/51</u> REGISTRAR'S SIGNATURE <u>J. H. Gable</u>		24. FUNERAL DIRECTOR ADDRESS <u>Charles R. Bast, Hancock, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. Welty

03057

Reg. Dist. No. 302

1. PLACE OF DEATH. COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Washington</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>117 High St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>James</u> (Middle) <u>Irwin</u> (Last) <u>Marker</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar.</u> <u>28</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 21, 1875</u>
9. AGE last birthday <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer, not a truck farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Wolfsville, Frederick Cty.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Marker</u>		14. MOTHER'S MAIDEN NAME <u>Cynthia Bowman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Rosa M. Marker</u>		18. MEDICAL CERTIFICATION <u>117 High St.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
Immediate cause (a) <u>Hodgkins Disease</u>		
Antecedent cause(s) (b) <u>448</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-25, 1951, to 3-28, 1951, that I last saw the deceased alive on 3-28, 1951, and that death occurred at 8:55 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

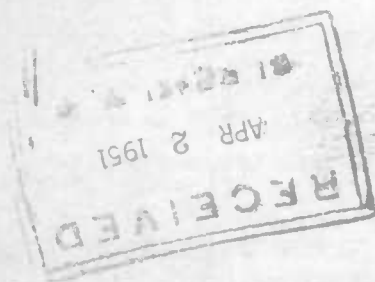
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/30/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
DATE REC'D BY LOCAL REG <u>Mar 30/1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR ADDRESS <u>Andrew K. Coffman, Hagerstown, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100105



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03058 301

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Downsville</u> TOWN <u>Downsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Downsville md.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Cercharington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Downsville</u> TOWN <u>Downsville</u> STREET ADDRESS (If rural, give location) <u>Downsville md.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>John</u> (Middle) <u>Frank</u> (Last) <u>Marshall</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>28</u> (Year) <u>1951</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 3 - 1870</u>	9. AGE last birthday <u>81-1-25 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>
11. BIRTHPLACE (State or foreign country) <u>Keedysville Wash. Co. md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>John Marshall</u>	14. MOTHER'S MAIDEN NAME <u>Wilhelmina Benty</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT AND ADDRESS <u>Leonard Marshall Downsville md.</u>	

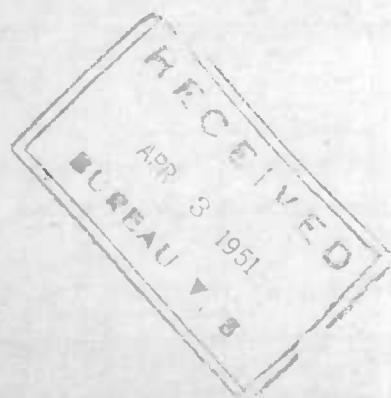
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Myocardial Infarction</u>		<u>3 years</u>
Antecedent cause(s) (b) <u>Arteriosclerosis</u>		<u>3 years</u>
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Jan. 1951</u> , to <u>Mar. 28 1951</u> , that I last saw the deceased alive on <u>Mar. 27</u> , 19 <u>51</u> , and that death occurred at <u>12:30</u> A.m., from the causes and on the date stated above.		
SIGNATURE <u>[Signature]</u> ADDRESS <u>W. W. Williams md.</u>		DATE SIGNED <u>3/30/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Buried</u>	<u>March 31, 1951</u>	<u>Mountain View Cemetery</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	LOCATION (City, town, or county) (State)
<u>March 30-51</u>	<u>E. Lee McElroy</u>	<u>Sharpsburg Wash. Co. md.</u>
24. FUNERAL DIRECTOR		ADDRESS
<u>W. J. Burt</u>		<u>9500 Boonsboro md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100105



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

03059

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR <u>near</u>) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Williamsport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>121 West Potomac Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Norman</u> (Middle) <u>Rollin</u> (Last) <u>McCardell</u>	4. DATE OF DEATH	(Month) <u>March</u> (Day) <u>9</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 31, 1898</u>
9. AGE last birthday <u>53</u> yrs. <u>1</u> Month <u>8</u> Days		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>J. Inspector State Roads Commission</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roads</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eugene McCardell</u>		14. MOTHER'S MAIDEN NAME <u>Effie King</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War</u>		16. SOCIAL SECURITY NO. <u>219-20-1290</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Edna McCardell; Williamsport, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
157x Immediate cause (a) <u>Cerebral Thrombosis</u>			<u>6 mos.</u>
Antecedent cause(s) (b) <u>46g</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>Jan - 15, 51</u>		19b. MAJOR FINDINGS OF OPERATION <u>1 (a)</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept.</u> , 19 <u>50</u> , to <u>Mar. 9</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Mar. 9</u> , 19 <u>51</u> , and that death occurred at <u>11:15 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u> (Degree or title)		ADDRESS <u>Williamsport, Md.</u> DATE SIGNED <u>Mar. 10, 51</u>	
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF <u>3/13/51</u>	NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>	LOCATION (City, town, or county) (State) <u>Smithsburg, Maryland</u>
DATE REC'D BY LOCAL REG. <u>Mar. 11, 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Albert L. Leaf; Williamsport, Maryland</u>	

533246

MARGIN RESERVED FOR BINDING

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03069
Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>821 W. Franklin Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Virga</u> (Middle) <u>Hoch</u> (Last) <u>Middlekauff</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 11, 1878</u> 9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days Hours Mln.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry K. Hoch</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Fisher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Albert H. Middlekauff</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
450.1 Immediate cause (a) <u>Lower thigh amputation of left leg due to arterio</u>		10 days
97 Antecedent cause(s) (b) <u>sclerotic gangrene of leg</u>		
(c) <u>Urinary Infection</u>		1 week
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>28 Feb 51</u>	19b. MAJOR FINDINGS OF OPERATION <u>arterio-sclerotic gangrene</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>W</u>	PLACE (Home, factory, street, office hldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

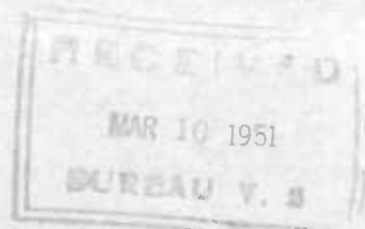
22. I hereby certify that I attended the deceased from 15 Jan, 1951, to 8 Mar, 1951, that I last saw the deceased alive on 7 Mar, 1951, and that death occurred at 2 30 A m., from the causes and on the date stated above.

SIGNATURE J J Lusby (Degree or title) ADDRESS 2307 Pthomas DATE SIGNED 8 Mar 51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar. 11, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown, Maryland</u> (State)
DATE REC'D BY LOCAL REG <u>Mar. 8, 1951</u>	REGISTRAR'S SIGNATURE <u>G. H. Bowers</u>	24. FUNERAL DIRECTOR <u>Fred W. Kraiss</u>	ADDRESS <u>Hagerstown, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Hauver

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Pennsylvania</u> COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pen Mar</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. County Hospital</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>BURGESS</u>	(Middle) <u>ALLEN</u>	(Last) <u>MILLER</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>12</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8/22/1896</u>
9. AGE last birthday <u>54</u> yrs.	If under 1 year Months Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Pen Mar, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Miller</u>		14. MOTHER'S MAIDEN NAME <u>May Shorb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Anna Mauds Miller Pen Mar Pa.</u>	
17. INFORMANT <u>Anna Mauds Miller Pen Mar Pa.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Obstruction Common Bile Duct

INTERVAL BETWEEN ONSET AND DEATH

6 wks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) CARCINOMA of PANCREAS (Primary)

3 mo +

(c) CARCINOMA of Lung, Rt. (Primary)

Surgically Removed

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>2/15/51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Probable CA. PANCREAS</u>	20. AUTOPSY?
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/29, 1951, to 3/13, 1951, that I last saw the deceased

alive on 3/13, 1951, and that death occurred at 5:40 P. m., from the causes and on the date stated above.

SIGNATURE Richard V. Hauver M.D. ADDRESS Hagerstown Md DATE SIGNED 3/13/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/15/51</u>	<u>Mt. View Cemetery</u>	<u>Emmitsburg,</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Mar. 12, 1951</u>	<u>Walter Y. Grove</u>	<u>Walter Y. Grove</u>	<u>Waynesboro, Pa.</u>	

564246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LETTER TO THE DIRECTOR, FBI, WASHINGTON, D.C.

RE: [illegible]



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03062

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and OR TOWN Hagerstown)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. Co. Hospital		STREET ADDRESS (If rural, give location) 142 Broadway	
3. NAME OF DECEASED (First) Howard (Middle) Alvin (Last) Miller		4. DATE OF DEATH (Month) Mar. (Day) 2 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 11-16-1900
9. AGE last birthday (50) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer	
10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Mercersburg, Pa.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Moses G. Miller	
14. MOTHER'S MAIDEN NAME Mary Devilbiss		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-09-2680		17. INFORMANT AND ADDRESS Mrs. Howard A. Miller, Hagerstown	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Adeno. carcinoma of Colon

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April, 1949, to March, 1951, that I last saw the deceased alive on 3-2, 1951, and that death occurred at 4:03 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION (Specify) Burial		DATE THEREOF 3-5-1951		NAME OF CEMETERY OR CREMATORY Fairview Cemetery		LOCATION (City, town, or county) (State) Mercersburg, Pa.	
DATE REC'D BY LOCAL REG. Mar. 3, 1951		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR C.M. Suter & Sons, Hagerstown, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290636



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

03063

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>921 Guilford Avenue</u>		STREET ADDRESS (If rural, give location) <u>921 Guilford Avenue</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Maurice</u> (Middle) <u>E.</u> (Last) <u>Miller</u>		(Month) <u>March</u> (Day) <u>31</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 28, 1878</u>
9. AGE last birthday <u>72</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City light plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jerimiah Miller</u>		14. MOTHER'S MAIDEN NAME <u>Annie Reynolds</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>Florence M. Miller Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cardio-Vascular System

INTERVAL BETWEEN ONSET AND DEATH

63 min

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 7/1/50, 19....., to 3/31/51, 19....., that I last saw the deceased alive on 3/24/51, 19....., and that death occurred at 10 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 3, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>April 3, 1951</u>	REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	24. FUNERAL DIRECTOR <u>Fred W. Kraiss</u>	ADDRESS <u>Hagerstown, Md.</u>	

290586

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A167



MARYLAND STATE DEPARTMENT OF HEALTH

03064

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
TOWN Hagerstown		TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital		STREET ADDRESS (If rural, give location) 70 W. Franklin St.	
3. NAME OF DECEASED (First) John (Middle) Russell (Last) Myers		4. DATE OF DEATH (Month) March (Day) 17 (Year) 1951	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 1-26-1897
9. AGE last birthday 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Petty Officer	
11. BIRTHPLACE (State or foreign country) Old Forge, Wash. Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Myers		14. MOTHER'S MAIDEN NAME Amanda Remley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWJ		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Myers, Jr. RFD 5 Hagerstown			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Pneumonia		one week
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

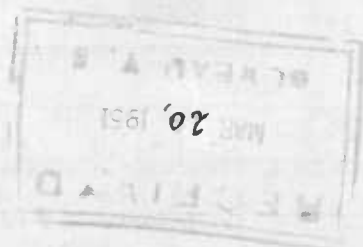
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) burial	DATE THEREOF 3-20-51	NAME OF CEMETERY OR CREMATORY Leitersburg Cemetery	LOCATION (City, town, or county) Leitersburg, Md.	(State)
DATE REC'D BY LOCAL REG. 18, 1951	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
		Scott F. Minnich & Son, Hagerstown		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

673916



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		MARYLAND LENGTH OF STAY (In this place) <u>6 months</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>202 Athol Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Lucretia Eleanor Clark</u> First (Last) (Middle)		4. DATE OF DEATH <u>March 25</u> 19 <u>57</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>June 21, 1866</u>		9. AGE last birthday <u>84</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George W. Ness</u>		14. MOTHER'S MAIDEN NAME <u>Joanna Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT AND ADDRESS <u>Hospital Record</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

6 hrs.

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Hypertensive Cardio-vascular Disease

May yes.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Gen. arterio-sclerosis.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from Aug. 11, 1950, to Mar. 25, 1957, that I last saw the deceased

alive on Mar. 25, 1957, and that death occurred at 7:25 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel Rai, M.D.

Ritchie Hospital, Cascade, Md.

3/25/57

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>3-27-57</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>		LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>3/26/57</u>		REGISTRAR'S SIGNATURE <u>O.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>John O. Mitchell & Sons, Inc.</u>		ADDRESS <u>1900 East W. Pl.</u>			

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pa</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Blue Ridge Summit, Pa</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		STREET ADDRESS (If rural, give location) <u>—</u>	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth</u> (First) <u>—</u> (Middle) <u>O'Brien</u> (Last)		4. DATE OF DEATH <u>3</u> (Month) <u>26</u> (Day) <u>1951</u> (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug. 16, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>73</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leahart Butke</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT AND ADDRESS <u>Hospital Record</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerosis, general, severe

INTERVAL BETWEEN ONSET AND DEATH

unknown

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Rheumatoid arthritis

20. AUTOPSY?

Yes ☐ No ☐

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
OF INJURY					

22. I hereby certify that I attended the deceased from Aug. 22, 1950, to Mar. 26, 1951, that I last saw the deceased alive on Mar. 24, 1951, and that death occurred at 9:08 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/29/51</u>		<u>New Cathedral Baltimore, Md.</u>		<u>3/26/51</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3/26/51</u>		<u>John A. Cochran</u>		<u>Easton Sons, Catonsville, Md.</u>		<u>WWWW Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03067

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Dargan</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. County Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Bernard</u>	(Middle) <u>Eugene</u>	(Last) <u>Otzelberger</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 12, 1882</u>
9. AGE last birthday <u>69</u> yrs.		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>14</u> (Year) <u>1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Antietam-Wash.-Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>George Otzelberger</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Giffit</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>214-14-6288</u>	
17. INFORMANT <u>Mrs. Eileen Parker</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Cerebral Hemorrhage</u>	<u>3 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Hypertension</u>	<u>5 yrs plus</u>
	(c) <u>Arteriosclerosis</u>	<u>5 yrs plus</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/11, 1951, to 3/14, 1951; that I last saw the deceased alive on 3/14, 1951, and that death occurred at 7:50 P.m., from the causes and on the date stated above.

SIGNATURE <u>Walter H. Shady M.D.</u>	(Degree or title)	ADDRESS <u>Sharpsburg, Md.</u>	DATE SIGNED <u>March 15, 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/17/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>	LOCATION (City, town, or county) (State) <u>Sharpsburg--Md</u>
DATE REC'D BY LOCAL REG. <u>Mar. 16, 1951</u>	REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	24. FUNERAL DIRECTOR <u>R. I. Earnshaw</u>	ADDRESS <u>--Keedysville, Md</u>

100105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Kneisley

03068

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>935 Concord St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>935 Concord St.</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN</u> (First) <u>FRANK</u> (Middle) <u>POTTS</u> (Last)		4. DATE OF DEATH <u>Mar 9 1951</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 5 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pangborn Corp.</u>	9. AGE last birthday <u>75</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Williamsport Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles Potts</u>		14. MOTHER'S MAIDEN NAME <u>Alice Worley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY No. <u>214-09-1842</u>	
17. INFORMANT AND ADDRESS <u>Harry K. Potts Sharpsburg Md</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

2 minutes

Antecedent cause(s)

(b)

Hypertensive Cardio-vascular Disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒ (STATE)

21. ACCIDENT (Specify) SUICIDE HOMICIDE

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-11, 1949, to 3-9, 1951, that I last saw the deceased alive on 2-26, 1951, and that death occurred at 9 a. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mar 9 1951Robert H. GowersAndrew K. Coffman Hagerstown Md

554VW

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03069

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN TOWN HAGERSTOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON CO. HOSPITAL		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN TOWN HAGERSTOWN STREET ADDRESS (If rural, give location) 127 HIGH STREET	
3. NAME OF DECEASED (Type or Print) MAMIE (First) BURYL (Middle) RAFFENSBERGER (Last)		4. DATE OF DEATH March (Month) 5 (Day) 1951 (Year)	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 6/30/1889
9. AGE last birthday 61 yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STOVER COOPER		14. MOTHER'S MAIDEN NAME HARRIET WILLINGHAM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)		16. SOCIAL SECURITY NO. 219-01-8600	
17. INFORMANT AND ADDRESS MR. LEON C HAMILTON, ASBURY PARK, N.J.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) 162x <i>Chronic Carcinoma</i>				<i>6 mos</i>	
Antecedent cause(s) (b) 47c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9/1/50, 1950, to 3/5, 1951, that I last saw the deceased alive on 3/5, 1951, and that death occurred at 8:40 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 3/8/51	NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	LOCATION (City, town, or county) Clarke County, Va.	(State)
DATE REC'D BY LOCAL REG. Mar. 7, 1951		REGISTRAR'S SIGNATURE W. J. Korman		24. FUNERAL DIRECTOR W. J. Korman	
				ADDRESS Hagerstown, Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Dr. Ditto

03070

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R# 1 Mt. Etna Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Hagerstown</u> STREET ADDRESS (If rural, give location) <u>R#1 Mt. Etna Road</u>	
3. NAME OF DECEASED (Type or Print) <u>DAVID</u> SEX <u>Male</u>	(First) <u>HERBERT</u> COLOR OR RACE <u>White</u>	(Middle) <u>REVELL</u> SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	(Last) <u>REVELL</u> DATE OF DEATH <u>March 31, 1951</u>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>
8. DATE OF BIRTH <u>3/23/41</u>		9. AGE last birthday <u>10</u> yrs. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>In grade school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Wash. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carlton C. Revell</u>		14. MOTHER'S MAIDEN NAME <u>Irene P. Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Carlton C. Revell Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

936.0 Immediate cause (a) Regulation by hanging
 Antecedent cause(s) (b) 195e
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH
6 hours

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>Hanging</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u> INJURY <u>While at work</u>	(CITY OR TOWN) <u>Hagerstown</u> (COUNTY) <u>Washington</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3-31-51 3⁰⁰ m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Accidentally hanging self while playing</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED 4/5/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
DATE REC'D BY LOCAL REG. <u>Apr. 3, 1951</u>	REGISTRAR'S SIGNATURE <u>Pharrell Bowers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03071

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hagerstown Hospital</u>		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg Rural</u> TOWN STREET ADDRESS (If rural, give location) <u>Route 2</u>	
3. NAME OF DECEASED (Type or Print) <u>Miss Bertha May Ridenour</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>March 16, 1951</u> (Month) (Day) (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Mar. 21, 1879</u>	9. AGE last birthday <u>71</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Duties</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Ringgold Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>William F. Ridenour</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Stevenson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT <u>William Newcomer, Smithsburg, Md. Rts.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Carcinoma of the bladder.</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Period of years.</u>
Antecedent cause(s) (b) <u>181x 52b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>	
(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 21, 1951, to March 16, 1951, that I last saw the deceased alive on March 15, 1951, and that death occurred at 2:25 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Susken WangM.D.Washington County Hospital3/16/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/19/51</u>	NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>	LOCATION (City, town, or county) <u>Smithsburg</u>	(State) <u>md</u>
DATE REC'D BY LOCAL REG. <u>Mar. 16, 1951</u>	REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	24. FUNERAL DIRECTOR <u>Walter J. Howe</u>		ADDRESS <u>Waynesboro Pa.</u>

720836

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03072

Reg. Dist. No. 386

The correct age
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.
is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie State Hospital</u>		STREET ADDRESS (If rural, give location) <u>Stonewall Park</u>	
3. NAME OF DECEASED (Type or Print) <u>Walter Arthur Russell</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>5/28/1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u>	9. AGE last birthday <u>76</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Keene, New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>William Swithin</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Carpenter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>none?</u>	
17. INFORMANT AND ADDRESS <u>Mrs Walter A. Russell Catonsville Md</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
443x Immediate cause (a) <u>Hypertensive Cardiovascular Disease</u>		<u>4 yrs</u>
93d Antecedent cause(s) (b) <u>multiple Cerebral Thrombozes</u>		<u>4 yrs</u>
(c) <u>General Atherosclerosis</u>		<u>4 yrs</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>March 4, 1951</u> , to <u>March 7, 1951</u> , that I last saw the deceased alive on <u>March 6, 1951</u> , and that death occurred at <u>4:45 A.M.</u> , from the causes and on the date stated above.	
SIGNATURE <u>Robert Bogan</u>	DATE SIGNED <u>3/7/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-10-51</u>
NAME OF CEMETERY OR CREMATORY <u>Bairview Cem</u>	LOCATION (City, town, or county) (State) <u>Harpers Ferry W. Va</u>
DATE REC'D BY LOCAL REG. <u>3/21/51</u>	REGISTERAR'S SIGNATURE <u>John P. Harrison</u>
24. FUNERAL DIRECTOR <u>J.C. Higginbotham</u>	ADDRESS <u>Ellicott City Md</u>

032868

RECEIVED

MAR 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03073
Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>220 Manila Avenue</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>220 Manila Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Edith</u>	(Middle) <u>Kathryn</u>	(Last) <u>Schuller</u>
6. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 24, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>64</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lewis Stambaugh</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Tipton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Arbra A. Schuller Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

Antecedent cause(s)

(b)

Hyperleucemic Cardiovascular Disease.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

15 Mins

10 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION no

19b. MAJOR FINDINGS OF OPERATION no

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
<u>no</u>	<u>INJURY</u>	<u>no</u>		
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
<u>no</u>		<u>no</u>		

22. I hereby certify that I attended the deceased from 9-15-, 1941, to March 9, 1951, that I last saw the deceased

alive on Feb. 23, 1951, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. Howard Yeager, M.D. Hagerstown, Md.

Mar. 9, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Mar. 12, 1951</u>	<u>Rose Hill Cemetery</u>	<u>Hagerstown, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR			
<u>Mar. 12, 1951</u>	<u>Fred W. Kraiss Hagerstown, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03074

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Pennsylvania COUNTY Adams	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Gettysburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital		STREET ADDRESS R. D. # 2 (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Clara (Middle) V. (Last) Semler	4. DATE OF DEATH	(Month) March (Day) 23, (Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Dec. 20, 1910
9. AGE last birthday 40 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OR WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward Semler		14. MOTHER'S MAIDEN NAME Winifred Kegan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mrs. Ray Guise Gettysburg, Pa.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

443x Immediate cause (a)

Nephrosclerosis, arteriolar

1 yr ±

131a Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive Cardio-vascular disease

10 yrs ±

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 5, 1951, to Mar 23, 1951, that I last saw the deceased

alive on Mar 22, 1951, and that death occurred at 8 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
CREMATION	Mar. 27, 1951	Charles Evans Cemetery	Reading, Pennsylvania	
DATE REC'D BY LOCAL	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
Mar. 24, 1951	Chas. H. Hoverson	Fred W. Kraiss	Hagerstown, Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03075
Reg. Dist. No. 304

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hancock</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>East Main St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hancock</u> STREET ADDRESS (If rural, give location) <u>East Main Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Robert</u> (Middle) <u>Francis</u> (Last) <u>Shives</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-1-71</u>
9. AGE last birthday <u>79</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman (Retired)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. R.R.</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	13. FATHER'S NAME <u>Jacob Shives</u>	14. MOTHER'S MAIDEN NAME <u>Mary Ellen Sweeny</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
16. SOCIAL SECURITY No. <u>-</u>	17. INFORMANT <u>Robert Francis Shives, Jr.</u>		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Chronic pyocardites</u>		
Antecedent cause(s) (b) <u>Cardiovascular renal disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Underty</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>57</u> , to <u>3/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/25</u> , 19 <u>57</u> , and that death occurred at <u>m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>A. M. Snapper MD</u>		ADDRESS <u>Hancock Md 3/24/57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3-29-51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cath. Cem.</u>	LOCATION (City, town, or county) <u>Hancock, Md.</u>
DATE REC'D BY LOCAL REG. <u>3/29/51</u>	REGISTRAR'S SIGNATURE <u>J. D. Heller</u>	24. FUNERAL DIRECTOR <u>Charles R. Bast</u>	ADDRESS <u>Hancock, Md.</u>

690506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VETERANS AFFAIRS
WASHINGTON, D. C.

RECEIVED
MAR 30 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03076 302
Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clear Spring, Md.</u> TOWN <u>Rural Clear Spring, Md.</u> STREET ADDRESS (If rural, give location) <u>Route 40 E. Clspg. Md.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Victor M. Spickler</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 11, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 17-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank teller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>2nd Natl. Bank</u>	9. AGE last birthday <u>70</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>David H. Spickler</u>		14. MOTHER'S MAIDEN NAME <u>Ida M. Harn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>220-10-2012</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Bessie E. Spickler-Clear Spring Md. R D</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>Massive hemorrhage into the gastrointestinal tract, cause undetermined</u>		(a)	<u>8 hours</u>
Antecedent cause(s) <u>Pneumonitis, (primary atypical pneumonia)</u>		(b)	<u>1 week.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>None</u>		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3-3-51, 19....., to 3-11-51, 19....., that I last saw the deceased alive on 3-11-51, 19....., and that death occurred at 11:30 A. m., from the causes and on the date stated above.

SIGNATURE Arthur Robert Cole MD ADDRESS Clear Spring, Maryland DATE SIGNED 3-12-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Mar. 14, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>	LOCATION (City, town, or county) <u>Near Clear Spring, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Mar. 13, 1951</u>		24. FUNERAL DIRECTOR <u>Elmer J. Karland</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

305716

RECEIVED
MAY 15 1951
U.S. DEPT. OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03077

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Friend</u> <u>Wheaton</u> LENGTH OF STAY (in this place) <u>1 year</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Friend</u> <u>Wheaton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Between Wheaton and Brunswick</u>		STREET ADDRESS (If rural, give location) <u>Between Wheaton and Brunswick</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Franklin Arlington Taulton</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 15 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-11-1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truckman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R. Co</u>	9. AGE last birthday <u>85</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Irvin Burr Taulton</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Harold Taulton</u> <u>Burrville Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>sight heart failure</u>		
Antecedent cause(s) (b) <u>age & cardiac decompensation</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>95c</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 13, 1951, to March 15, 1951, that I last saw the deceased alive on March 15, 1951, and that death occurred at none m., from the causes and on the date stated above.

SIGNATURE (Degree or title) <u>William H. Duncan, M.D.</u>	ADDRESS <u>Brunswick Maryland</u>	DATE SIGNED <u>3/16/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE <u>3-18-51</u>	NAME OF CEMETERY OR CREMATORY <u>Reformed</u>
LOCATION (City, town, or county) (State) <u>Burrville Md.</u>	24. FUNERAL DIRECTOR <u>C. A. Smith & Son</u>	ADDRESS <u>Burrville Md.</u>
DATE REC'D BY LOCAL REG. <u>Mar. 16/1951</u>	REGISTRAR'S SIGNATURE <u>Mar. 16/1951</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

690506

RECEIVED
MAR 19 1951
FBI - NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH COUNTY <u>Washington Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Penna</u> COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural R 2</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mercesburg Pa</u>	
TOWN <u>Today</u>		TOWN <u>Mercesburg Pa</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gate way Comm. Home</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) <u>Viola</u> (First) <u>X</u> (Middle) <u>Taylor</u> (Last)		4. DATE OF DEATH <u>Mar</u> (Month) <u>23</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>7/4/1883</u>
9. AGE last birthday <u>67</u> yrs.		10. If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Near Mercesburg Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Straley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Clarke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Chas N Taylor</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF	While at Not While			
INJURY	Work <input type="checkbox"/> At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from 3-23, 1951, to 3-25, 1951, that I last saw the deceasedalive on 3/27/51, and that death occurred at 2:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Mar. 25-51</u>	<u>Fair View</u>	<u>Mercesburg Pa</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-25-51</u>	<u>Wm M. Taylor</u>	<u>D.J. Guinger</u>	<u>Mercesburg Pa</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Little 215 1/2 Wash

RECEIVED
APR 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. Novenstein

03078

302

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garlock Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>S. Potomac St.</u>	
3. NAME OF DECEASED (First) <u>CLARA</u> (Middle) <u>JANE</u> (Last) <u>TRONE</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 27, 1859</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>91</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>St. James, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Lewis Trone</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hise</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Junior Ball Washington, DC</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive Cardiovascular disease

Antecedent cause(s)

(b) ---

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) ---II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov. 9, 1950 to March 27, 1951, that I last saw the deceased alive on March 27, 1951, and that death occurred at 7:35 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

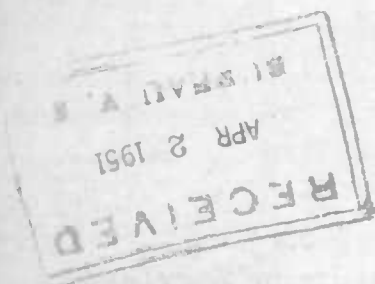
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/30/51</u>	NAME OF CEMETERY OR CREMATORY <u>Funkstown Cemetery</u>	LOCATION (City, town, or county) <u>Funkstown Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>March 9, 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

03079

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH - COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Potomac State Hospital</u>		STREET ADDRESS (If rural, give location) <u>479 Mitchell Ave.</u>	
3. NAME OF DECEASED (First) <u>Fannie</u> (Middle) <u>Elizabeth</u> (Last) <u>Turner</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>	8. DATE OF BIRTH <u>3/11/91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>waitress</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lucas Trent</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Cabbage</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>70</u>	
17. INFORMANT AND ADDRESS <u>Hoop. records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral arteriosclerosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Heart Disease

(c) General arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 9 Nov, 1950, to 27 Mar., 1951, that I last saw the deceased alive on 27 Mar, 1951, and that death occurred at 12 40 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/30/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>3-27-51</u>		REGISTRAR'S SIGNATURE <u>John R. Cochran</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		ADDRESS <u>7208 Hagerstown, Md</u>



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03080

CERTIFICATE OF DEATH

Reg. Dist. No. 3.0.5

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Mt. Lema Rural</u> TOWN <u>Mt. Lema Rural</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Boonsalus Md. R. 2.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lema Rural</u> TOWN <u>Mt. Lema Rural</u> STREET ADDRESS (If rural, give location) <u>Boonsalus Md. R. 2.</u>	
3. NAME OF DECEASED (Type or Print) <u>Walter Franklin Weddle</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 23, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 31 - 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Paper Hanger & Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>74-1-22</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Mt. Lema Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph E. Weddle</u>		14. MOTHER'S MAIDEN NAME <u>Emma Harrison</u>	
15. (Was) DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Luther Winge Boonsalus Md. R. 2.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a).....

Chr. Myocarditis

Antecedent cause(s)

(b).....

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c).....

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/23/57, 19....., to 3/23/57, 19....., that I last saw the deceasedalive on 3/23/57, 19....., and that death occurred at 6 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 24, 1957John H. EastWm. J. East & Sons Boonsalus Md

564246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03081

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>512 Salem Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u> (Middle) <u>Edward</u> (Last) <u>Willson</u>	4. DATE OF DEATH	(Month) <u>Mar.</u> (Day) <u>28</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1-29-1887</u>
9. AGE last birthday <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)
<u>Race Horse Trainer</u>		<u>10b. KIND OF BUSINESS OR INDUSTRY</u>	<u>Hagerstown, Maryland</u>
13. FATHER'S NAME <u>Walter D. Willson</u>		14. MOTHER'S MAIDEN NAME <u>Frances Aumen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>World war</u> (If yes, give war or dates of service) <u>71</u>		16. SOCIAL SECURITY No. <u>219-20-0419</u>	
17. INFORMANT AND ADDRESS <u>Mrs. A. L. Foreman, Hagerstown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Bronchopneumonia -

INTERVAL BETWEEN ONSET AND DEATH

? 7 days.

Antecedent cause(s)

(b)

Operation: Gastrojejunostomy

7 days.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Thrombosis of abdominal aorta.

19a. DATE OF OPERATION <u>March 21, 1951</u>	19b. MAJOR FINDINGS OF OPERATION <u>Old adhesion stenosing opening from pylorus to duodenum</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Hagerstown</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>Washington D.C.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 9, 1951, to March 28, 1951, that I last saw the deceased

alive on March 28, 1951, and that death occurred at 2 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Richard T. Benford

M.D.

1135 Patmore Ave.

March 29, 1951

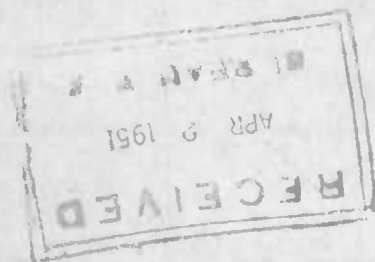
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3-31-1951</u>	<u>Rose Hill Cemetery</u>	<u>Hagerstown, Md.</u>	
DATE REC'D BY LOCAL	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>March 29, 1951</u>	<u>Robert H. Bowers</u>	<u>C.M. Suter & Sons</u>	<u>Hagerstown, Md.</u>	

920 859

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03082

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>HALFWAY, HAGERSTOWN</u> (in <u>MD</u> yrs.)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HALFWAY, HAGERSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 GLENSIDE AVE.</u>		STREET ADDRESS (If rural, give location) <u>10 GLENSIDE AVE.</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN</u> (First) <u>CLARK</u> (Middle) <u>WILLSON</u> (Last) <u>SR.</u>		4. DATE OF DEATH <u>MARCH</u> (Month) <u>11</u> (Day) <u>19</u> (Year) <u>51</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>10/28/1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FOOD DIST.</u>	9. AGE last birthday <u>78</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES PERRY WILLSON</u>		14. MOTHER'S MAIDEN NAME <u>SARAH W. McCORKEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>MRS. J. C. WILLSON JR.</u>		<u>HAGERSTOWN, MD.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
442x Immediate cause	(a) <u>Arterio-sclerotic cardiovascular renal disease with myocardial failure</u>		<u>10 yrs +</u>
1310 Antecedent cause(s)	(b) _____		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>none</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan, 1946, to 11 Mar, 1951, that I last saw the deceased alive on 10 Mar, 1951, and that death occurred at 7:45 A m., from the causes and on the date stated above.

SIGNATURE J. J. Lusby (Degree or title) ADDRESS 2300 Potomac Hagerstown Md DATE SIGNED 11 Mar 51

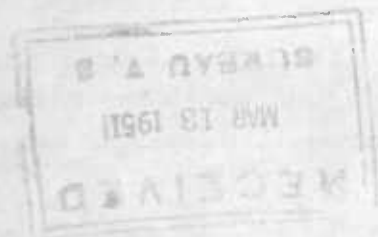
23. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>	DATE <u>3/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Green Hill Cem</u>	LOCATION (City, town, or county) <u>Clarke County, Va.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Nov. 11. 1951</u>	REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	24. FUNERAL DIRECTOR <u>W. J. Normant</u>	ADDRESS <u>Hagerstown Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4490609



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03083
Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u> LENGTH OF STAY (in this place) <u>5 years</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>13 High St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>13 High St.</u>	
3. NAME OF DECEASED (Type or Print) MARY (First) LOUISE (Middle) YEAKLE (Last)		4. DATE OF DEATH March 23 1951 (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>7/27/1857</u>
9. AGE last birthday <u>93</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.		10. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Clearspring, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Samuel Miller</u>		14. MOTHER'S MAIDEN NAME <u>Lethea Moyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Melchora Cowden Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) ARTERIOSCLEROTIC HEART DISEASE

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. SENILITY

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

NONE

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct. 16, 1946 to Mar. 23, 1951, that I last saw the deceasedalive on Mar. 20, 1951, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/26/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>	LOCATION (City, town, or county) <u>St. Paul Wash. Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Mar. 26, 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr. Yeager

03084

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>134 Randolph Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LELIA</u>	(Middle) <u>VIOLA</u>	(Last) <u>YOUNG</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 22, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>55</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Scott Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hennesy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Paul M. Young</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>Acute nephritis</u>	(a) <u>Obstruction of Bile Ducts Infection.</u>	<u>3 weeks plus</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>life unknown.</u>	(b) <u>life unknown.</u>	<u>3 weeks.</u>
(c) <u>Anemia</u>		<u>5 days</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 18, 1951, to Mar. 22, 1951, that I last saw the deceased alive on Mar. 22, 1951, and that death occurred at 10:46 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/26/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
DATE REC'D BY LOCAL REG. <u>Mar. 24, 1951</u>	REGISTRAR'S SIGNATURE <u>Charles H. Brown</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

